THIRD PARTY AND INSURANCE INFORMATION

Name: Birthdate: Case#:

1. Does anyone in your home currently have health insurance including Medicare? Yes No
Do not list Medicaid, PCN, or CHIP. If you answered yes, complete Section 1.

2. Has anyone had Insurance that has ended in the past 6 months? Yes No
If you answered yes, enter the information in Section 2.

3. Do you have insurance available which you have not enrolled in? Yes No
If you answered yes, complete Section 2.

4. Does someone in your home have a major medical need*? Yes No
Who has the medical need?_____ What is the medical need?_____
If yes, do you have: 1. Insurance available which you have not purchased? Yes No
2. Insurance that has ended in the past 60 days? Yes No
*Pregnancy is considered a major medical need. If you answered yes, enter the information in Section 2.

5. Have you or any household member been injured in an accident or assault? Yes No
If you answered yes, complete Section 3.

6. Is any other person required to pay medical expenses for anyone in your household? Yes No
If yes, person's name _____ Phone Number_____

7. Has anyone in your household ever served in the military? Yes No
Name_____ Dates of Service _____

Section 1 - Insurance Information (If you answered NO to question 1, do not complete this section)

Name of Insurance Company_____ Phone #_____
Address of Insurance Company _____ Group # _____
Policyholder Name _____ Policy # _____
Policyholder Date of Birth _____ Policyholder Social Security Number _____
If insurance is through an employer, list employer name and phone _____
Premium $_____ Date Due_____ How Often? _____
Names of Individuals Covered:

Name of 2nd Insurance Company_____ Phone #_____
Address of Insurance Company _____ Group # _____
Policyholder Name_____ Policy #_____
Policyholder Date of Birth _____ Policyholder Social Security Number _____
If insurance is through an employer, list employer name and phone _____
Premium $_____ Date Due_____ How Often? _____
Names of Individuals Covered (if not listed on the insurance card):

Section 2 - Buy-Out/PCN Information

Name and Phone of Insurance Company_____
Policyholder Name_____ Policy # _____
Employer Name & Phone (if applicable) _____
If not through an employer, how is insurance available?_____

Section 3 - Accident or Assault Information (If you answered NO to question 5, do not complete this section)

Please check the type of incident: ☐ automobile ☐ assault ☐ work-related ☐ slip/ fall ☐ dog bite
☐ medical malpractice ☐ other, please explain_____
Name of person(s) injured:_____
Date of incident:_____ Was a police report filed? ❑ Yes ❑ No
Police department: _____ Police Report Number: _____
Name of Attorney: _____ Phone number: _____

The information on this form is correct to the best of my knowledge and is furnished as a condition of eligibility for medical assistance. I authorize any person or organization with information regarding my insurance or information on this form to release that information to the Department of Health, Division of Health Care Financing or designee.

As consideration for medical assistance, I assign to the Utah Department of Health all my rights to benefits for medical services or payments from any third party up to the amount of medical assistance provided to me by the Department. I authorize the Department of Health to submit its claim directly to the third party. I authorize that any payment of benefits from a third party be paid directly to the Department of Health. If I receive medical assistance from the Department of Health, I will give the Department any money I collect from an insurance policy or any other third party obligated to pay for my medical expenses. I agree to hold harmless any person or organization making payment to the Department of Health because of this agreement. I agree to cooperate with the Department of Health in identifying and providing information to assist the Department in pursuing any third party obligated to pay for my medical expenses.

Client Signature _____ Date _____ Spouse Signature _____ Date _____

OFFICE USE ONLY --- Information must be updated at review.

BUYOUT potential? ☐ YES ☐ NO Immediate Action Needed? **To pursue BUYOUT, call A-I 538-7018 or J-Z 538-6474 FAX 536-0963** **(Phone Numbers for Office Use ONLY)**											
Date:											
Initials:											
Changes:* Yes/No											
ORS Packet											
MMIS Input Date											

Update changes on a new Form 19 or TPL notice **(ALBY or ALHI) as well as MMIS.*